NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
Provider Support
Certification and Attestation for Primary Care Rate Increase

DHCFP
Provider Support
1100 E. William St.
Carson City, NV 89701
Fax (775) 684-3720

## Section I: Instructions

**Please complete the information in the sections II and IV or V, sign and return by mail or fax to the address listed above**

## Section II: Provider Information

| PROVIDER NAME | | BUSINESS NAME (if applicable) | |
|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP |
| COUNTY | PROVIDER TELEPHONE NO. | PROVIDER FAX NO. | PROVIDER EMAIL ADDRESS |
| DESIGNATED CONTACT NAME | DESIGNATED CONTACT PHONE NUMBER | DESIGNATED CONTACT E-MAIL ADDRESS | |
| NPI | MEDICARE NUMBER | STATE LICENSE NUMBER | EIN NUMBER | TAXONOMY NUMBER |

**Check specialty(s) that apply to you:**

☐ **Family Practice** ☐ **General Internal Medicine** ☐ **Pediatrics**

**List any Subspecialties:**

**Are you a Managed Care Program Provider?** ☐ Yes ☐ No

If **YES, which health plan(s) do you provide services for?** ☐ **Amerigroup** ☐ **Health Plan of Nevada (HPN)**

## Section III: Information

Section 1902(a)(13)(C) of the Social Security Act specifies that physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine are primary care providers. Those that render evaluation and management codes and services related to immunization administration for vaccines and toxoids for specified codes would be eligible for reimbursement.

As proposed in 42 CFR 447 "Payment for Services," in order to be eligible for the increased payment the following requirements must be met. The provider must:

- Be a physician defined in 42 CFR 440.50, or under the personal supervision of a physician with specialist designation in family practice, general internal medicine and pediatrics or a subspecialty recognized by the **American Board of Medical Specialties, American Board of Physician Specialties, or the American Optometric Association**:
- Be a board certified in the specialty or subspecialty; or
- Have furnished evaluation and management (E&M) and vaccines services that equal at least 60% of the Medicaid codes billed during the most recently completed Calendar Year.

## Section IV: American Board of Medical Certification

Complete this section **only** if you have a certification from the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA). (attach copy of certification if available)

| **ABMS, ABPS, or AOA** Certification effective date(s) | Begin Date: | End Date: |
|---|---|---|

I attest that I have a certification recognized by the American Board of Medical Specialties, American of Physician Specialties, or the American Osteopathic Association and meet the requirements as required by federal and state regulation to receive the increased payment.

| *Signature:* | *Printed Signature:* | *Date:* |
|---|---|---|

## Section V: 60% Attestation

Complete this section only if you do not have a certification from the American Board of Medical Specialties, American Board of Physician Specialties, or the American Osteopathic Association but at least 60% of your total billings are E&M and vaccine administration codes. (Codes are specified by Federal and State Regulation)

**Current Enrolled providers only** (those who have billing history)

I attest that I am eligible primary care specialist or subspecialist but I do not have a certification recognized by the American Board of Medical Specialties. I attest that at least 60% of my total billings for the previous calendar year were for the E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive payment.

**New providers only** (those who have no billing history)

I attest that I am an eligible primary care specialist or subspecialist but I do not have a certification recognized by the American Board of Medical Specialist. I attest that at least 60% of my total billings **will be** for qualified E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive the increased payment.

| *Signature:* | *Printed Name:* | *Date:* |
|---|---|---|

## FOR DHCFP USE ONLY

| ☐ Certified ☐ 60% | Certification Verified (attach print-out): | Date Verified: |
|---|---|---|
| Forwarded to: | Forwarded to: | Forwarded To: |
| Staff Signature: | | Date: |